NORTHERN FAMILY
CHIROPRACTIC & REHAB

Pediatric Patient Confidential Intake Form

Date: (mm/dd/yyyy)

Child's Last name: _____ **Child's First Name:** _____

Date of Birth: __/____/____ **Age:** _____ **Gender:** **Male / Female**

mm/ dd / yyyy

Parent Name(s): _____

Are they the child's guardian? ☐ Yes ☐ No

If no, name of guardian(s): _____

Name and ages of siblings: _____

Address: _____

Suite/Apt #: _____ **City:** _____ **Postal Code:** _____

Home Phone #: _____ **Work Phone #:** _____

Cell Phone #: _____ **Email:** _____

Pediatrician: _____ (Name) _____ (Address) _____

Permission to send medical doctor a progress letter, if needed: YES / NO

How did you hear about our clinic?

- ☐ Friend or Acquaintance (name): _____
- ☐ Family member (name): _____
- ☐ Another Health Professional (please specify): _____
- ☐ Our Signage
- ☐ Our website
- ☐ Facebook/Instagram
- ☐ Other (please specify): _____

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Areas of Concern

Please specify the major complaint(s) of the child:

1) _____

2) _____

3) _____

How long has the condition existed?

Is it getting? ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Are there any previous diagnosis/treatment for this condition? And by whom?

Is the child on any medications/supplements?

List any Surgery/Accident/Falls/Illnesses:

Does your child play sports? How many times per week?

16 9th Street
Hearst, ON
POL 1N0
(705) 362-5352

105 Brunelle Road N
Kapuskasing, ON
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During pregnancy did the child's mother:

- ☐ Have an injury
- ☐ Have good nutrition
- ☐ Exercise
- ☐ Smoke or drink alcohol
- ☐ Take any medication

As a baby:

Is/was child breastfed?	☐ Yes	☐ No
Is/was child a head banger?	☐ Yes	☐ No
Did child ever fall on head?	☐ Yes	☐ No
Did child ever fall down stairs?	☐ Yes	☐ No

List date of last:

Physical examination by MD: _____

Blood test: _____

Chest x-ray: _____

Urine test: _____

The birthing process:

- ☐ Long delivery
- ☐ Difficult delivery
- ☐ Forceps/vacuum extraction
- ☐ Head bruising
- ☐ Caesarean
- ☐ Breach
- ☐ Induced labour
- ☐ Drugs during birth
- ☐ Hospital birth

Any Recent occurrences:

- ☐ Depression or Anxiety
- ☐ Death (Family/Friends)
- ☐ Divorce/Separation of parents
- ☐ Family problems
- ☐ Sleep Disturbances

Has or does child have problems with:

- ☐ Bowel
- ☐ Breastfeeding difficulties
- ☐ Bedwetting
- ☐ Recurrent bladder infections
- ☐ Recurrent throat infections
- ☐ Recurrent ear infections
- ☐ Reflux
- ☐ Co-ordination
- ☐ Learning difficulties
- ☐ Speech difficulties
- ☐ Attention Deficit Disorder
- ☐ Messy handwriting
- ☐ Sleep
- ☐ Eczema
- ☐ Allergies
- ☐ Asthma
- ☐ Growing pains
- ☐ Headaches
- ☐ Colic
- ☐ Moodiness
- ☐ Epilepsy
- ☐ Sinuses

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Family Health History

Many health problems are the result of hereditary spinal weaknesses. This information will give us a better picture of the child's total health. List family members who have had any health problems such as migraines, strokes, heart disease, blood diseases, arthritis, spina bifida etc.

Relationship to Child	Past or Present Health Problems

Has your child ever been evaluated by:

☐ Pediatrician ☐ Neurologist ☐ Psychiatrist / Psychologist

☐ Occupational Therapist ☐ Speech or Language Pathologist ☐ Naturopathic Doctor

☐ Other, please specify: _____

Consent to treatment and examination of a minor:

I give consent for the chiropractors at Northern Family Chiropractic and Rehab to perform a chiropractic assessment my child on the initial visit, and on subsequent visits as deemed necessary. This will include physical, neurological and orthopaedic examinations, as well as reflexes and ranges of motion. I hereby consent to the administration of chiropractic care as deemed necessary to my child during this assessment, and for subsequent visits.

☐ I agree.

_____ _____

Name of Child **Name of Parent or Guardian**

_____

Signature of Parent or Guardian

_____

Date

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Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge.

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree.

Cancellation Policy

Your appointment time is reserved for you. We respectfully request 24 hours' notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours' notice, or miss their appointment, will be charged a cancellation fee.

☐ I am aware of the Cancellation Policy.

Please read the following statements: then check off each box and sign below:

☐ Chiropractic treatment may be covered under extended health insurance at work, and or no fault insurance (motor vehicle accident), or WSIB (inured at work), however; in the event that the third party billing does not cover my treatment fees I hereby confirm that I am responsible for any outstanding balances.

☐ I have answered all questions and filled in areas that have requested information. The information supplied by me in this questionnaire is accurate and complete. I understand that the withholding of health care information could jeopardize my receiving safe and effective treatment.

☐ The chiropractors at Northern Family Chiropractic & Rehab work together as a team, and often collaborate with each other regarding their patients' diagnosis and care. I hereby consent to my Northern Family Chiropractic & Rehab Health Care Provider to collaborate on my case.

☐ In the event I am not able to answer the phone when called by the staff of Northern Family Chiropractic & Rehab, I hereby authorize the staff to leave a message for me regarding the details of my appointment at the phone numbers provided.

☐ I hereby give my consent for Northern Family Chiropractic & Rehab to either obtain or release medical information as deemed necessary, in accordance with privacy policies.

Signature:_____ **Date:** _____

Witness:_____ **Date:** _____

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